

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05980

5991

CERTIFICATE OF DEATH

Reg. Dist. No. 51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cabret		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown		c. LENGTH OF STAY IN 1b Life							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown							
3. NAME OF DECEASED (Type or print) W. Ralph Crawford		d. STREET ADDRESS							
4. DATE OF DEATH June 21, 1956		Month	Day	Year					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1899	9. AGE (In years from last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months 10	11. IF UNDER 24 HRS. Days 19	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Cabret County, Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John S. Crawford		14. MOTHER'S MAIDEN NAME Anna S. Bowen							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 3		17. INFORMANT Mr. Beriah T. Crawford - Huntingtown, Md		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b)		DUE TO							
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Huntingtown		(County) Md	(State)
21. I certify that I attended the deceased from 8/1/1939, to 6/20/1956, that I last saw the deceased alive on 6/8/1956, and that death occurred at M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Huntingtown, Md					DATE SIGNED 6/22/56
ACTUAL SIGNATURE G. J. Weems									
PHYSICIAN'S NAME (Type) G. J. Weems				Huntingtown, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 23, 1956		22b. DATE THEREOF June 23, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Huntingtown Methodist		22d. LOCATION (City, town, or county) Huntingtown		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE O. A. Harkness & Son - Mutual		ADDRESS		24a. REC'D BY REGISTRAR Dr. Harkness		24b. REGISTRAR'S SIGNATURE Dr. Harkness			
				Date June 27, 1956					

DEPARTMENT OF STATE
CABLEGRAM TO BUCHAREST

BUREAU V. A.
RECEIVED
JUN 27 1956

05981

Reg. Dist. No. 52

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, at least execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

VS. A15ME(S)
5M 9/55

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>DC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Bead</i>		c. LENGTH OF STAY IN 1b <i>3 days.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
3. NAME OF DECEASED (Type or print) <i>Roland Lee Edwards</i>		First <i>R</i>	Middle <i>L</i>
		Last <i>ee</i>	4. DATE OF DEATH <i>June 18</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>Oct 10 1876</i>	9. AGE (in years last birthday) <i>79</i> yrs.
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Baker</i>	
11. KIND OF BUSINESS OR INDUSTRY <i>Baking</i>		12. BIRTHPLACE (State or foreign country) <i>Md</i>	
13. FATHER'S NAME <i>Robert Edwards</i>		14. MOTHER'S MAIDEN NAME <i>George Margaret Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>579-05568</i>	
		17. INFORMANT <i>Mrs. Eliza T. Edwards</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been cutting the grass</i>		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>6</i> p.m. <i>18</i> 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or Town) <i>W. Bead Calvert Md</i>	
(County) <i></i>		(State) <i></i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		DATE SIGNED <i>6/18/58</i>	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial 6/21/58</i>		22b. DATE THEREOF <i>6/21/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL FACILITY <i>Cedar Hill Cemetery</i>		22d. LOCATION (City, Town, or County) <i>Seaford Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. W. Ward</i>		ADDRESS <i>300 4th St. Seaford Del.</i>	
24a. RECD BY REGISTRAR DATE <i>6-21-58</i>		24b. REGISTRAR'S SIGNATURE <i>Clara B. Cox</i>	

BUREAU V. S.

NOV 20 1955

RECEIVED

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5993 CERTIFICATE OF DEATH

05982

Reg. Dist. No. 57

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)
X Prince Frederick		6 days.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Calvert County Hospital	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) OF DEATH	
(First) Effie Palmer		(Middle) June 12 (Year) 1956	
(Last) Evans			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 18, 1878
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Home	9. AGE last birthday 78 yrs.	11. BIRTHPLACE (State or foreign country) Pensy Wardia
13. FATHER'S NAME Charles Palmer	14. MOTHER'S MAIDEN NAME Mary Wood	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. 161-01-9628A	17. INFORMANT ADDRESS Eileen Sansbury - Standard	INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442x IMMEDIATE CAUSE (A) Hypertension C.V.R disease			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. <input type="checkbox"/> at work <input type="checkbox"/> Not white, <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 1/19, 1955, to 10, 1956, that I last saw the deceased alive on 1956, and that death occurred at 9:15 A.M. from the causes and on the date stated above. SIGNATURE			
ADDRESS (Street, city, town, state)			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF June 15, 1956	NAME OF CEMETERY OR CREMATORIAL West Laurel Hill Cemetery	LOCATION (City, town, or county) Philadelphia, Pa (State)
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE H. W. Ward	25. FUNERAL DIRECTOR'S SIGNATURE G. A. Harkness & Son - Mutual, Md.	
DATE 6-14-56	ADDRESS		

29 CERTIFICATE OF DEATH

BUREAU V. S.

JUN 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5994

CERTIFICATE OF DEATH

Reg. Dist. No. 05983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendship, Md.</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Friendship</i>				
3. NAME OF DECEASED (Type or print) <i>Ed. M.</i>		Middle <i>First</i>	4. DATE OF DEATH <i>July 1, 1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 26, 1868</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			
13. FATHER'S NAME <i>William C. Towler</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane Lane</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs Lawrence Hartman, Husband</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio vascular renal disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ca of Sigmoid</i>		DUE TO (c) <i>Partial sigmoid obstruction - stricture</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Partial sigmoid obstruction - stricture</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>				
20c. TIME OF INJURY Hour p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Owings, Md.</i>	20f. (City or town) <i>Owings, Md.</i>	(County) <i>Owings, Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>June 1, 1956</i> to <i>June 20, 1956</i> , that I last saw the deceased alive on <i>June 20, 1956</i> , and that death occurred at <i>Friendship, Md.</i> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>H. W. Ward</i>	M.D.			ADDRESS (Street, city or town, state) <i>Owings, Md.</i>		
DATE SIGNED <i>6/20/56</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 23, 1956</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Friendship Cemetery</i>	22d. LOCATION (City, town, or county) <i>Friendship, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. H. Hartman</i>		ADDRESS <i>Owings, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>6/21/56</i>		24b. REGISTRAR'S SIGNATURE <i>Grace L. Hartman</i>	

REGIEN
BUREAU Y.A.

JUN 27 1956

REGISTRATION OF TRADE-MARKS
CLASSIFICATION OF TRADE-MARKS

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Forward to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the register prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
5995 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 105984

Reg. Dist. No. 57

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>		c. LENGTH OF STAY IN lb		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Calvert</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Baby Boy Green</i>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX <i>M</i>		6. COLOR OR FACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <i>Leslie Roy</i>		14. MOTHER'S MAIDEN NAME <i>Ida Green</i>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>+</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>754.3</i>		DUE TO <i>Infant Jaundice Ovule</i>		INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>8 hrs duration</i>		(b) DUE TO <i></i>									
(c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Found dead in bed</i>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6/29/56</i>			
22a. BURIAL OR CREMATION, REMOVAL (Specify) <i>6-30-56</i>		22b. DATE THEREOF <i>6-30-56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Hope</i>		22d. LOCATION (City, town, or county) <i>Sunderland</i>		(State) <i>Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Jewell Prince Fred.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>7-3-56</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>					

RECEIVED
BUREAU V. S.

JUL 5 1958

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AFSC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

5996

05985

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH COUNTY <i>Calvert</i> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>W. Beach</i>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i> COUNTY <i>Calvert</i> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>W. Beach Md.</i>			
3. NAME OF DECEASED (Type or Print) <i>Wilfred McDonald</i>				4. DATE OF DEATH 6 24 56			
5. SEX <i>7</i>	6. COLOR OR FACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i></i>	8. DATE OF BIRTH <i>Aug. 13 1894</i>	9. AGE last birthday <i>61</i> yrs.	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if ired) <i>Dug stone D.C.</i>				11. BIRTHPLACE (State or foreign country) <i>Calvert Co. D.C.</i>			
13. FATHER'S NAME <i>Fred W. Densert</i>				14. MOTHER'S MAIDEN NAME <i>Suzanna Bortels</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i></i>				16. SOCIAL SECURITY NO. <i></i>			
17. INFORMANT & ADDRESS <i>Suzanna Bortels</i>				18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <i>Cardiac embolism.</i> ANTECEDENT CAUSE(S) DUE TO (B) <i>Cardiac & Liver</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <i>Sleep ap</i> Was telephone and dogged dead			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <i>3 min.</i> <i>5 min.</i> <i>?</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY (Av. office, bridge, etc.) <i>Home</i>		21c. WHERE DID INJURY OCCUR? (City or town) <i>None</i>		(County) <i></i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <i>Aug 9 56</i>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>9:50 AM</i>			
22. I hereby certify that I attended the deceased from <i>May 1, 1956</i> , to <i>June 24, 1956</i> , that I last saw the deceased alive on <i>June 22, 1956</i> , and that death occurred at <i>9:50 AM</i> , from the causes and on the date stated above. SIGNATURE <i>W. Ward</i> ADDRESS (Street, city, town, state) <i>1000 E. 20th St. Baltimore, MD</i> DATE SIGNED <i>6/26/56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6/27/56</i>		NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>		LOCATION (City, town, or county) <i>Baltimore, MD</i>	
24. REC'D BY REGISTRAR <i></i>		REGISTRAR'S SIGNATURE <i>Grace L. Hutchins</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. M. Lee Sons Co - Wash, DC</i>		ADDRESS <i></i>	
DATE <i>6/26/56</i>							

1948-1951

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5997

CERTIFICATE OF DEATH

05986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert County</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>5 1/2 hrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>George</i>	Middle <i>W</i>	4. DATE OF DEATH <i>Janey</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/24/1893</i>
9. AGE (In years last birthday) <i>62 yrs.</i>		10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS Days <i>15</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Samuel Janey</i>		14. MOTHER'S MAIDEN NAME <i>Eliza Hardman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>214-16-9480</i>	
17. INFORMANT <i>Catherine Janey - daughter - Lusby, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		CEREBRAL HEMORRHAGE	
DUE TO (b) HYPERTENSIVE C.V.D.			
DUE TO (c) GENERALIZED SCLEROSIS			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 15, 1956</i> , to <i>June 15, 1957</i> , that I last saw the deceased alive on <i>June 15, 1956</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above, ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>R. D. Bellone</i> M.D. <i>S. Sherman</i> PHYSICIAN'S NAME (Type) <i>R. D. Bellone - M.D.</i>			
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>6-19-56</i>		22b. DATE THEREOF <i>6-19-56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Brookside</i>		22d. LOCATION (City, town, or county) <i>Island Creek Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. J. Secord, Jr. Fred, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>6-18-56</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 3 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

88117

5998 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 52

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, telegraph or call the Chief Medical Examiner's Office and advise him of the cause of death. If the certificate is "pending" in pencil in Item 18, Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		a. STATE		Md.		b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Ches. Beach		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Unknown		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)																	
3. NAME OF DECEASED (Type or print)		First JUANITA		Middle		Last KING		4. DATE OF DEATH		Month June		Day 9		Year 1956			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months		11. IF UNDER 24 HRS Days		12. IF UNDER 24 HRS Hours			
Female		Colored		WIDOWED <input type="checkbox"/> OWN <input type="checkbox"/> DIVORCED <input type="checkbox"/>		unknown		25 yrs.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
unknown								Unknown									
13. FATHER'S NAME								14. MOTHER'S MAIDEN NAME									
unknown								Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)								16. SOCIAL SECURITY NO.									
17. INFORMANT								Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I. DEATH WAS CAUSED BY, Fracture dislocation of 1st cervical vertebra																	
IMMEDIATE CAUSE (a) 35-4X																	
Crushed chest																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
(b) Multiple fractures of vertebral column																	
(c) Avulsion of abdominal wall																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.																	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																	
Fell out of one car and run over by another																	
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
Hour 12:30		p.m. 6/9/1956		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		street		Chesapeake Beach		Calvert		Md.					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>														DATE SIGNED	
EXAMINER'S NAME (Type)		William V. Lovitt, Jr., M.D.														6/11/56	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)									
July 1/56				Univ. of Med. Med. School		Baltimore, Md.											
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE											
						Elsie B. Cox											
						E-J.											



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
599 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05987

Reg. Dist. No. 51

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Wash. DC</i> b. COUNTY <i>DC</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>		c. LENGTH OF STAY IN 1b c. STREET ADDRESS <i>5622 Sherrie Blau NW</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) <i>James Eller Maceson</i>		First <i>James</i>	Middle <i>Eller</i>
Last <i>Maceson</i>		4. DATE OF DEATH <i>6 Aug 1956</i>	Month <i>Aug</i> Day <i>6</i> Year <i>1956</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 3, 1891</i>
9. AGE (In years to birthday) <i>65 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Logistics</i>	11. BIRTHPLACE (State or foreign country) <i>DC</i>	12. CITIZEN OF WHAT COUNTRY? <i>United States</i>
13. FATHER'S NAME <i>Samuel Maceson</i>	14. MOTHER'S MAIDEN NAME <i>May Grillo</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>11-111-1111</i>		17. INFORMANT <i>Edward Maceson</i>	Address <i>5733-9th NW</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Caduceus asthma</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>had been under all night with asthma.</i>			
DUE TO (c) <i>had been under all night with asthma.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>had been under all night with asthma.</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Found at 12 N</i>	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, grocery, street, office bldg., etc.) <i>House</i>
20f. (City or town) <i>Calvert MD</i>		(County) <i>Calvert</i> (State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. FUNERAL CREMATION, REMOVAL (Specify) <i>None</i>		22b. DATE THEREOF <i>6/26/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Rock Creek DC</i>
22d. LOCATION (City, town, or county) <i>Wash. DC</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Donald W. Ward</i>		ADDRESS <i>111-1111 NW</i>	24a. REC'D BY REGISTRAR DATE <i>6/23/56</i>
		24b. REGISTRAR'S SIGNATURE <i>H. Ward</i>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05988
51

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>H. Beach</i>		c. LENGTH OF STAY IN 18 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Anthony Joseph Meyers Jr.</i>		First	Middle
		Last	4. DATE OF DEATH Month Day Year <i>Jan 31 1979</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 31 1979</i>
9. AGE (in years and months) <i>77 yrs.</i>	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. US. AT OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Police Dept. Government</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Government</i>	
11. BIRTHPLACE (State or foreign country) <i>W. Beach</i>		12. CITIZEN OF WHAT COUNTRY? <i>W. Beach</i>	
13. FATHER'S NAME <i>Anthony J. Meyers Jr.</i>		14. MOTHER'S MÄDEN NAME <i>Mary Lawrence</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Mr. Franklin Meyers, W. Beach</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Address INTERVAL BETWEEN ONSET AND DEATH <i>Cardiac failure</i>	
DUE TO Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Found dead in bed beside his wife</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 7:30 a. m. 1979		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>
		20f. (City or town) <i>W. Beach Calvert</i>	(County) <i>Calvert</i> (State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <i>A. W. Ward</i>			
ACTUAL SIGNATURE <i>A. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>James T. Ryan, Inc.</i>		DATE SIGNED <i>6/26/56</i>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/29/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James T. Ryan, Inc.</i>		ADDRESS <i>317 Pa. Ave. S.E.</i>	24a. REC'D BY REGISTRAR DATE <i>June 27, 1976</i>
			24b. REGISTRAR'S SIGNATURE <i>Elie M. Cato</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05989

CERTIFICATE OF DEATH

Reg. Dist. No. 51

6701

1. PLACE OF DEATH
a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Prince Frederick

c. LENGTH OF STAY IN 1b

6 months

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Calvert Co. Hosp. Annex

3. NAME OF
DECEASED
(Type or print)

First Middle Last

4. SEX

5. COLOR OR RACE

Female

white

6. MARRIED NEVER MARRIED 7. WIDOWED DIVORCED 4. DATE
OF
DEATH

Month

Day

Year

6

19

1956

8. DATE OF BIRTH

9. AGE (In years
from birth)

78 yrs.

10. IF UNDER 1 YEAR

11. IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S.

13. FATHER'S NAME

John Lutz

14. MOTHER'S MAIDEN NAME

Mary Meyer.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

Yes, no, or unknown

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Roberts, Prince Frederick, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which

gave rise to immediate

cause (a), stating the under-

lying cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

Cardio-Vascular - Renal Disease

5 years

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Mental condition has been poor for several years

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ 19 _____

p. m. _____

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 1, 1956, to June 19, 1956, that I last saw the deceased

alive on June 19, 1956, and that death occurred at 6 P.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

Cremation

22b. DATE THEREOF

6/20/56

22c. NAME OF CEMETERY OR CREMATORIAL

Lee's Crematory

22d. LOCATION (City, town, or county)

Washington, D.C.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

J.W. Lee Son Co.

ADDRESS

Wash. D.C.

24a. REC'D BY REGISTRAR

DATE 6-19-56

24b. REGISTRAR'S SIGNATURE

H. W. Ward

BULLETT

JUN



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6102

CERTIFICATE OF DEATH

05990

Reg. Dist. No. 52

1. PLACE OF DEATH a. COUNTY Cabret MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Cabret	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barstow	c. LENGTH OF STAY IN 1b life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barstow	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CLARENCE	Middle H. Monnett	4. DATE OF DEATH June 26, 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Owner		10b. KIND OF BUSINESS OR INDUSTRY Farming	10c. BIRTHPLACE (State or foreign country) Cabret Co., Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles W. Monnett	14. MOTHER'S MAIDEN NAMEJulianne Hutchins		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. No	17. INFORMANT Esther A. Monnett - Barstow, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Ca. of Stroke - Malnutrition	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1955</u> to <u>June 1956</u> , that I last saw the deceased alive on <u>June 26, 1956</u> , and that death occurred at <u>St. Leonard's, Md.</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 6/27/56	
ACTUAL SIGNATURE R. De Villarreal	M.D.		
PHYSICIAN'S NAME (Type)	ST. LEONARD'S, MD. 6/27/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 29, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Full Gospel Cemetery	22d. LOCATION (City, town, or county) Prince Frederick, Md.
23. FUNERAL DIRECTOR'S SIGNATURE A. A. Hawkness & Son - Mutual, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 6-27-56	24b. REGISTRAR'S SIGNATURE H. W. Ward

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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REF

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10K

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05991

CERTIFICATE OF DEATH

Reg. Dist. No. 51

6003

1. PLACE OF DEATH

COUNTY	Calvert	MARYLAND	STATE	Maryland	COUNTY	Calvert
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Length of Stay (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	STREET ADDRESS		
TOWN			TOWN	Adelina		
HOSPITAL OR INSTITUTION OR STREET ADDRESS					(If rural give location)	

3. NAME OF DECEASED (Type or Print)

(First) Hattie (Middle)

(Last) Parker

4. DATE (Month) (Day) (Year)

6 22 1956

5. SEX

F

6. COLOR OR RACE

C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH

Feb. 28

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

House wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Benjamin Parker.

14. MOTHER'S MAIDEN NAME

Grace Freedland.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS

Bertine Green Huntington, Md

18. MEDICAL CERTIFICATION

157X	IMMEDIATE CAUSE (A)	Antecedent Cause(s) DUE TO (B)	Giving Rise to the Above Cause Due to (C)	Interval Between Onset and Death
				3 months

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)	(County)	(State)
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town)	(County)	(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1, 1956 to May 2, 1956, that I last saw the deceased alive on May 1, 1956, and that death occurred at Home M. from the causes and on the date stated above.

SIGNATURE H. W. Ward ADDRESS (Street, city, town, state) Baltimore, Md DATE SIGNED 6/2/56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)

24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS

DATE <u>6-22-56</u>	REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	FUNERAL DIRECTOR'S SIGNATURE <u>P. J. Sewell, Jr., Fred. Md</u>	ADDRESS
DATE <u>6-22-56</u>	REGISTRAR'S SIGNATURE <u>H. W. Ward</u>	FUNERAL DIRECTOR'S SIGNATURE <u>P. J. Sewell, Jr., Fred. Md</u>	ADDRESS

THE STATE OF MASSACHUSETTS

COURT OF COMMON PLEAS

RECEIVED
1856

1856

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05992

6704

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)						
Calvert Co. Hospital MARYLAND		a. STATE	b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
Prince Frederick		Owings						
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS						
2 days		Owings						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
Calvert Co. Hospital								
3. NAME OF DECEASED (Type or print)		First	Middle					
Jane		J	nette					
4. DATE OF DEATH		Month	Day					
5-28-1956		5	23					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
Female		White		5-28-1875	81			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife				Calvert Co. Md		Calvert Co. Md		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
John Paddy		Mary Lyle						
15. WAS DECLASSED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Mary Turner, Owings Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cardiac Decompensation			3 days			
422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		arterio sclerotic A.V. disease						
(b) DUE TO								
(c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from June 20, 1956, to June 23, 1956, that I last saw the deceased alive on June 23, 1956, and that death occurred at 1 P.M., from the causes and on the date stated above.					ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE					M.D. Prince Frederick		Sept 1956	
PHYSICIAN'S NAME (Type)		Page C. Jett			Page C. Jett, Prince Frederick, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)
Burial		6/26/56		Mt Harmony		Owings		Md.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
John L. Hutchins		Owings Md.		Date 5/13/56		John L. Hutchins		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and notify event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH

1956-39

1956

DEATH

1956

BUREAU V. L.

JUL 2 1956

RECEIVED